FOR OHF USE

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036533

Facility Name: WILLOW CREST NURSING PAVILION

Address: 515 NORTH MAIN (Number) SANDWICH (City) 60548 (Zip Code)

County: DEKALB

Telephone Number: (815) 786-8426 **Fax #** (815) 786-6487

IDPA ID Number: 363718794001

Date of Initial License for Current Owners: 01/11/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	58	Skilled (SNF)	58	21,170	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,340	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,803	3,541	2,876	12,220	8
9	SNF/PED					9
10	ICF	15,244	6,661	237	22,142	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,047	10,202	3,113	34,362	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.16%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/1/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 2,414

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	170,227	16,519	9,824	196,570		196,570		196,570			1
2	Food Purchase		143,767		143,767	(15,713)	128,054	(424)	127,630			2
3	Housekeeping	77,155	20,875		98,030		98,030		98,030			3
4	Laundry	42,573	13,320		55,893		55,893		55,893			4
5	Heat and Other Utilities			118,254	118,254		118,254	752	119,006			5
6	Maintenance	57,354	45,975	33,537	136,866		136,866	3,631	140,497			6
7	Other (specify):*							499	499			7
8	TOTAL General Services	347,309	240,456	161,615	749,380	(15,713)	733,667	4,458	738,125			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,154,638	49,485	153,036	1,357,159		1,357,159	(65)	1,357,094			10
10a	Therapy		844	11,569	12,413		12,413	(204)	12,209			10a
11	Activities	53,227	3,907	1,748	58,882		58,882		58,882			11
12	Social Services	46,239	1,829	1,500	49,568		49,568		49,568			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,254,104	56,065	169,053	1,479,222		1,479,222	(269)	1,478,953			16
	C. General Administration											
17	Administrative	58,339			58,339		58,339	144,484	202,823			17
18	Directors Fees											18
19	Professional Services			292,295	292,295		292,295	(253,872)	38,423			19
20	Dues, Fees, Subscriptions & Promotions			76,820	76,820		76,820	(41,866)	34,954			20
21	Clerical & General Office Expenses	12,632	3,260	39,565	55,457		55,457	24,426	79,883			21
22	Employee Benefits & Payroll Taxes			317,048	317,048	15,713	332,761		332,761			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,812	1,812		1,812	200	2,012			24
25	Other Admin. Staff Transportation			344	344		344		344			25
26	Insurance-Prop.Liab.Malpractice			79,995	79,995		79,995	617	80,612			26
27	Other (specify):*							20,932	20,932			27
28	TOTAL General Administration	70,971	3,260	807,879	882,110	15,713	897,823	(105,079)	792,744			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,672,384	299,781	1,138,547	3,110,712		3,110,712	(100,890)	3,009,822			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WILLOW CREST NURSING PAVILION #0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			113,832	113,832		113,832	81,552	195,384			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,455	23,455		23,455	147,678	171,133			32
33	Real Estate Taxes			54,352	54,352		54,352	2,187	56,539			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			4,964	4,964		4,964	6,398	11,362			35
36	Other (specify):*											36
37	**TOTAL Ownership**			676,603	676,603		676,603	(242,185)	434,418			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	30,363	54,905	115,599	200,867		200,867	(2,565)	198,302			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):*	16,037			16,037		16,037	(16,037)				43
44	**TOTAL Special Cost Centers**	46,400	54,905	179,109	280,414		280,414	(18,602)	261,812			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,718,784	354,686	1,994,259	4,067,729		4,067,729	(361,677)	3,706,052			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,855)	30		9
10	Interest and Other Investment Income	(12,263)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(424)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(6,680)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(40,193)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(35,111)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (122,526)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(239,151)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (239,151)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (361,677)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
WILLOW CREST NURSING PAVILION

ID# 0036533
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Prior Period Adjustment - Pharmacy	$ (582)	39	1
2	Prior Period Adjustment - Maintenance	(299)	6	2
3	Prior Period Adjustment - Dues, Subscriptions	(371)	20	3
4	Prior Period Adjustment - Clerical/General	(321)	21	4
5	Prior Period Adjustment - Insurance	(1,859)	26	5
6	Prior Period Adjustment - Interest Expense	(314)	32	6
7	COPE Dues	(1,813)	20	7
8	Discounts Earned	(540)	21	8
9	Amortization Cost (Bldg. Co)	(3,350)	31	9
10	Franchise Tax (Bldg. Co.)	(200)	21	10
11	State Replacement Tax (Bldg. Co.)	(2,681)	21	11
12	Bank Charges (Bldg. Co.)	(275)	21	12
13	Capitalized Repairs & Maintenance	(3,540)	6	13
14	Marketing	(16,837)	43	14
15	Penalties (Bldg. Co.)	(268)	21	15
16	Bank Charges	(2,661)	21	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91
92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(35,111)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(424)											(424)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			752									752	5
6	Maintenance	(3,839)		2,305	5,165								3,631	6
7	Other (specify):*			60		439							499	7
8	**TOTAL General Services**	(4,263)		3,117	5,165	439							4,458	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records							(65)					(65)	10
10a	Therapy						(204)						(204)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**						(204)	(65)					(269)	16
	C. General Administration													
17	Administrative				144,484								144,484	17
18	Directors Fees													18
19	Professional Services			(253,872)									(253,872)	19
20	Fees, Subscriptions & Promotions	(42,377)		511									(41,866)	20
21	Clerical & General Office Expenses	(13,626)	3,424	29,977	4,651								24,426	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			200									200	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(1,859)		2,476									617	26
27	Other (specify):*			5,153		15,779							20,932	27
28	**TOTAL General Administration**	(57,862)	3,424	(215,555)	149,135	15,779							(105,079)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(62,125)	3,424	(212,438)	154,300	16,218	(204)	(65)					(100,890)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(27,855)	106,014	3,393									81,552	30
31	Amortization of Pre-Op. & Org.	(3,350)	3,350											31
32	Interest	(12,577)	157,270	2,985									147,678	32
33	Real Estate Taxes			2,187									2,187	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			6,398									6,398	35
36	Other (specify):*													36
37	TOTAL Ownership	(43,782)	(213,366)	14,963									(242,185)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(582)					(1,973)	(10)					(2,565)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(16,037)											(16,037)	43
44	TOTAL Special Cost Centers	(16,619)					(1,973)	(10)					(18,602)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(122,526)	(209,942)	(197,475)	154,300	16,218	(2,177)	(75)					(361,677)	45

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Willowcrest Building, LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 480,000	Willowcrest Building LLC		$	$ (480,000)	1
2	V	32	Interest Income		Willowcrest Building LLC		(716)	(716)	2
3	V	32	Interest Expense		Willowcrest Building LLC		157,986	157,986	3
4	V	30	Depreciation		Willowcrest Building LLC		106,014	106,014	4
5	V	31	Amortization Cost		Willowcrest Building LLC		3,350	3,350	5
6	V	21	Franchise Tax		Willowcrest Building LLC		200	200	6
7	V	21	State Replacement Tax		Willowcrest Building LLC		2,681	2,681	7
8	V	21	Bank Charges		Willowcrest Building LLC		275	275	8
9	V	21	Penalty		Willowcrest Building LLC		268	268	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 480,000			$ 270,058	$ * (209,942)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 752	$ 752	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.		2,305	2,305	16
17	V	7	EMP.BEN. - GEN. SERVICES		DYNAMIC HEALTH CARE CONS.		60	60	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.		1,528	1,528	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.		511	511	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.		29,977	29,977	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.		200	200	21
22	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.		2,476	2,476	22
23	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.		5,153	5,153	23
24	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.		3,393	3,393	24
25	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.		2,985	2,985	25
26	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.		2,187	2,187	26
27	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.		6,398	6,398	27
28	V								28
29	V								29
30	V								30
31	V	19	BOOKKEEPING SERVICES	255,400	DYNAMIC HEALTH CARE CONS.			(255,400)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 255,400			$ 57,925	$ * (197,475)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 5,165	$ 5,165	15
16	V	10	NURSING CMP - SUE G.						16
17	V	17	ADMIN. CMP. - M. MAUER				28,867	28,867	17
18	V	17	ADMIN. CMP. - M. AARON				42,699	42,699	18
19	V	17	ADMIN. CMP. - F. AARON				30,071	30,071	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN						20
21	V	17	ADMIN. CMP. - S. KOPLIN				8,210	8,210	21
22	V	17	ADMIN. CMP. - D. MAGAFAS				9,657	9,657	22
23	V	17	ADMIN. CMP. - E. CASSON						23
24	V	17	ADMIN. CMP. - S. BOGEN						24
25	V	17	ADMIN. CMP. - S. LEVY				11,188	11,188	25
26	V	17	ADMIN. CMP. - HOWARD ALTER						26
27	V	17	ADMIN. CMP. - NON-OWNER				13,792	13,792	27
28	V	21	CLERICAL CMP. - S. AARON				4,651	4,651	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 154,300	$ * 154,300	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 439	$ 439	15
16	V	15	EMP. BEN.- SUE G.						16
17	V	27	EMP. BEN.- M. MAUER				1,255	1,255	17
18	V	27	EMP. BEN.- M. AARON				1,600	1,600	18
19	V	27	EMP. BEN.- F. AARON				4,442	4,442	19
20	V	27	EMP. BEN.- S. GOLDSTEIN						20
21	V	27	EMP. BEN.- S. KOPLIN				2,599	2,599	21
22	V	27	EMP. BEN.- D. MAGAFAS				1,339	1,339	22
23	V	27	EMP. BEN.- E. CASSON						23
24	V	27	EMP. BEN.- S. BOGEN						24
25	V	27	EMP. BEN.- S. LEVY				1,615	1,615	25
26	V	27	EMP. BEN.- HOWARD ALTER						26
27	V	27	EMP. BEN.- NON-OWNER				2,056	2,056	27
28	V	27	EMP. BEN. - S. AARON				873	873	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 16,218	$ * 16,218	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$ 11,344	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$ 11,140	$ (204)	15
16	V	19	PROFESSIONAL FEES		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			17
18	V	39	ANCILLARY SERVICES	110,445	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	108,472	(1,973)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 121,789			$ 119,612	$ * (2,177)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	454	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	389	$ (65)	15
16	V	39	ANCILLARY EXPENSE	70	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	60	(10)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 524			$ 449	$ * (75)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	Owner	Administrative	10.78%	See Attached	3.18	6.36%	Dynamic All	$ 28,867	17-7	1
2	Maurice Aaron	Owner	Administrative	23.79%	See Attached	3.5	7.00%	Dynamic All	42,699	17-7	2
3	Fred Aaron	Owner	Administrative	13.10%	See Attached	7	15.55%	Dynamic All	30,071	17-7	3
4	Sharon Aaron	Owner	Clerical	0.56%	See Attached	3.18	7.95%	Dynamic All	4,651	21-7	4
5	Sue Koplin	Owner	Administrative	0.56%	See Attached	4.59	11.48%	Dynamic All	8,210	17-7	5
6	Diania Magafas	Owner	Administrative	0.56%	See Attached	4.97	11.05%	Dynamic All	9,657	17-7	6
7	Dennis Nehmer	Owner	Maintenance	0.56%	See Attached	3.5	8.76%	Dynamic All	5,165	6-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 129,320		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	441,841	13	$ 9,671	$	34,362	$ 752	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	441,841	13	29,639	3,380	34,362	2,305	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	441,841	13	778		34,362	60	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	441,841	13	19,651		34,362	1,528	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	441,841	13	6,566		34,362	511	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	441,841	13	385,463	300,175	34,362	29,977	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	441,841	13	2,576		34,362	200	7
8	26	INSURANCE	PATIENT DAYS	441,841	13	31,835		34,362	2,476	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	441,841	13	66,254		34,362	5,153	9
10	30	DEPRECIATION	PATIENT DAYS	441,841	13	43,634		34,362	3,393	10
11	32	INTEREST	PATIENT DAYS	441,841	13	38,384		34,362	2,985	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	441,841	13	28,121		34,362	2,187	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	441,841	13	82,269		34,362	6,398	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 744,841	$ 303,555		$ 57,925	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	10	59,032	59,032	4	5,165	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	32,744	32,744			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	12	363,103	363,103	3	28,867	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	10	487,988	487,988	4	42,699	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	193,312	193,312	7	30,071	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	37	2	153,497	153,497			6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	8	71,542	71,542	5	8,210	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	87,437	87,437	5	9,657	8
9	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	38	1	31,246	31,246			9
10	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	2	54,060	54,060			10
11	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	12	140,632	140,632	4	11,188	11
12	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	12	157,563	157,563	4	13,792	13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	12	58,502	58,502	3	4,651	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,902,658	$ 1,902,658		$ 154,300	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	10	5,020		4	439	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40	1	3,128				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	12	15,782		3	1,255	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	10	18,288		4	1,600	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	6	28,556		7	4,442	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	37	2	25,672				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	8	22,644		5	2,599	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	12,125		5	1,339	8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	38	1	3,418				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45	2	5,010				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	12	20,299		4	1,615	11
12	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,296				12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	12	23,491		4	2,056	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	12	10,982		3	873	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 195,711	$		$ 16,218	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						11,140	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION						108,472	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 119,612	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						389	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						60	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 449	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	American National Bank		X	Mortgage			$ 3,350,000	$ 2,271,619			$ 157,986	1
2												2
3												3
4												4
5												5
	Working Capital											
6	American National Bank		X					366,000			23,141	6
7												7
8												8
9	TOTAL Facility Related						$ 3,350,000	$ 2,637,619			$ 181,127	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Interest Income										(12,263)	11
12	Interest Income (Bldg. Co.)										(716)	12
13	Dynamic Allocation										2,985	13
14	TOTAL Non-Facility Related						$	$			$ (9,994)	14
15	TOTALS (line 9+line14)						$ 3,350,000	$ 2,637,619			$ 171,133	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	52,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	54,539	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,539	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	54,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	56,539	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	32,926	8
1998	48,905	9
1999	49,489	10
2000	50,345	11
2001	52,352	12

2002 Accrual = 52,352 X 1.03 = 52,923 (Rounded to 54,000)

Dynamic Allocation $2187

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILLOW CREST NURSING PAVILION COUNTY DEKALB

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-26-433-024	Facility	$ 52,352.00	$ 52,352.00
2.	10-23-404-059-0000	Home Office Allocation	$ 26,130.00	$ 2,032.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 78,482.00	$ 54,384.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILLOW CREST NURSING PAVILION COUNTY DEKALB

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,430 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 327,859	1
2					2
3	TOTALS			$ 327,859	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	21,410		20	1,071	1,071	13,386	9
10	Various			1991	9,997		20	-		9,918	10
11	Various			1992	4,279		20	214	214	2,256	11
12	Various			1993	26,868		20	1,344	1,344	12,599	12
13	Various			1994	8,312		20	416	416	3,552	13
14	Various			1995	3,234		20	162	162	1,221	14
15	Various			1996	17,411		20	870	870	5,368	15
16	Various			1997	68,499		20	3,425	3,425	17,240	16
17	Various			1998	16,889		20	845	845	3,756	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,579,232	66,135		66,236	101	272,918	68
69	Financial Statement Depreciation			35,547			(35,547)		69
70	TOTAL (lines 4 thru 69)		$ 2,756,131	$ 101,682		$ 74,583	$ (27,099)	$ 342,214	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,756,131	$ 101,682		$ 74,583	$ (27,099)	$ 342,214	1
2	HANDRAILS	1999	14,756		20	738	738	2,952	2
3	HOT WATER BOILER	1999	6,563		20	328	328	1,312	3
4	HOT WATER BOILER	1999	9,018		20	451	451	1,804	4
5	CUBICLE	1999	506		20	25	25	100	5
6	DYNALOCK SYSTEM	1999	4,966		20	248	248	971	6
7	NURSES STATION	1999	9,316		20	466	466	1,825	7
8	ENTRANCE DOOR	1999	1,898		20	95	95	372	8
9	DOOR	1999	557		20	28	28	110	9
10	HAND RAILS & BUMPERS	1999	4,438		20	222	222	851	10
11	ATRIUM A/C	1999	5,755		20	288	288	1,104	11
12	CAMERAS & MONITORS	1999	2,750		20	138	138	529	12
13	DOOR/FRAME	1999	553		20	28	28	107	13
14	GENERATOR	1999	14,595		20	730	730	2,798	14
15	CURTAINS/DRAPES	1999	2,013		20	101	101	362	15
16	WINDOW TREATMENTS	1999	5,002		20	250	250	896	16
17	SOLFIT & FACCIA	1999	4,970		20	249	249	892	17
18	TILE	1999	2,087		20	104	104	364	18
19	TILE	1999	302		20	15	15	53	19
20	SOLFIT & FACCIA	1999	5,322		20	266	266	953	20
21	NEW FLOORS	1999	2,310		20	116	116	387	21
22	COVE CASE	1999	459		20	23	23	77	22
23	NEW ENT EDGING	1999	1,286		20	64	64	213	23
24	COVE BASE	1999	459		20	23	23	75	24
25	FLOOR TILES	1999	2,022		20	101	101	328	25
26	CEILING TILE	1999	236		20	12	12	39	26
27	FLOOR TILES	1999	2,364		20	118	118	384	27
28	GENERATOR SYSTEM	1999	29,189		20	1,459	1,459	3,822	28
29	GENERATOR SYSTEM UPG	1999	5,496		20	275	275	871	29
30	ELEVATOR REPAIRS	1999	435		20	11	11	34	30
31	ELEVATOR REPAIRS	1999	1,031		20	26	26	81	31
32	ELEVATOR REPAIRS	1999	311		20	8	8	25	32
33	SHOWER TILE	1999	591		20	15	15	46	33
34	TOTAL (lines 1 thru 33)		$ 2,897,687	$ 101,682		$ 81,604	$ (20,078)	$ 366,951	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,897,687	$ 101,682		$ 81,604	$ (20,078)	$ 366,951	1
2	AIR CONDITIONER	1999	1,098		20	55	55	275	2
3	AIR CONDITIONER	1999	1,098		20	55	55	266	3
4	AIR CONDITIONER	1999	1,098		20	55	55	257	4
5	AIR CONDITIONER	1999	1,098		20	55	55	248	5
6	AIR CONDITIONER	1999	1,098		20	55	55	238	6
7	AIR CONDITIONER	1999	1,098		20	55	55	238	7
8	BORDER	1999	192		20	10	10	30	8
9	WALLPAPER	1999	586		20	29	29	87	9
10	WALLPAPER	1999	670		20	34	34	102	10
11	WALL GUARD	1999	1,170		20	59	59	177	11
12	WALLPAPER	1999	1,245		20	62	62	186	12
13	WALLPAPER	1999	5,192		20	260	260	780	13
14	ROOM SIGNAGES	1999	1,323		20	66	66	198	14
15	COOLING REPAIRS	1999	542		20	27	27	81	15
16	BATHROOM FIXTURES	1999	600		20	30	30	90	16
17	FIRE ALARM	1999	1,140		20	57	57	171	17
18	PLUMBING WORK	1999	1,040		20	52	52	156	18
19	ROOF RENOVATION	2000	23,155		20	1,158	1,158	3,474	19
20	SHOWER REMODELING	2000	673		20	34	34	102	20
21	SHOWER REMODELING	2000	638		20	32	32	96	21
22	FIRE DOORS	2000	1,939		20	97	97	291	22
23	TILE & COVE BASE	2000	838		20	42	42	123	23
24	TILE	2000	1,791		20	90	90	263	24
25	COVE BASE	2000	462		20	23	23	67	25
26	WATER HEATER REPAIR	2000	2,081		20	104	104	295	26
27	SECURITY CAMERAS	2000	1,925		20	96	96	272	27
28	CUBICLE HOOKS	2000	112		20	6	6	17	28
29	TILES	2000	507		20	25	25	71	29
30	CUBICLE TRACKS&CURTA	2000	507		20	25	25	71	30
31	TILE	2000	1,912		20	96	96	272	31
32	SHOWER REMODELING	2000	405		20	20	20	55	32
33	TILE	2000	699		20	35	35	96	33
34	TOTAL (lines 1 thru 33)		$ 2,955,619	$ 101,682		$ 84,503	$ (17,179)	$ 376,096	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,955,619	$ 101,682		$ 84,503	$ (17,179)	$ 376,096	1
2	BUZZERS	2000	175		20	9	9	25	2
3	WATER TANK REPAIR	2000	667		20	33	33	91	3
4	ELEVATOR DOOR EDGE	2000	2,270		20	114	114	304	4
5	TILE	2000	210		20	11	11	28	5
6	BOILER REPAIR	2000	458		20	23	23	59	6
7	KICK PLATES	2000	392		20	20	20	52	7
8	SECURITY MONITOR	2000	290		20	15	15	40	8
9	PARKING LOT PAVING	2000			20				9
10	BATHROOM TILE	2000	30,000		20	1,500	1,500	3,875	10
11	BATHROOM TILE	2000	15,000		20	750	750	1,938	11
12	DINING ROOM TILES	2000	4,500		20	225	225	581	12
13	ROOF REPAIR	2000	1,425		20	71	71	195	13
14	SPRINKLER REPAIR	2000	1,625		20	81	81	203	14
15	LIGHTING	2000	1,770		20	89	89	223	15
16	WATER PUMP	2000	1,567		20	78	78	189	16
17	TILE	2000	1,792		20	90	90	218	17
18	FIXTURES	2000	1,587		20	79	79	184	18
19	COVE BASE	2000	318		20	16	16	37	19
20	TILE	2000	2,599		20	130	130	303	20
21	FAUCETS	2000	699		20	35	35	82	21
22	BATHROOM SINKS	2000	538		20	27	27	63	22
23	BATHROOM SINKS&FAUCE	2000	1,072		20	54	54	126	23
24	TILE	2000	5,425		20	271	271	655	24
25	COVE BASE	2000	837		20	42	42	95	25
26	WALL GUARDS	2000	589		20	29	29	65	26
27	WALL BORDERS	2000	1,772		20	89	89	200	27
28	SOUND SYSTEM	2000	840		20	42	42	95	28
29	TILE	2000	307		20	15	15	35	29
30	TILE	2000	205		20	10	10	23	30
31	DEFROST CLOCK	2000	725		20	36	36	78	31
32	FIRE PANELS	2000	2,887		20	144	144	312	32
33	WALL BORDERS	2000	1,828		20	91	91	197	33
34	TOTAL (lines 1 thru 33)		$ 3,039,988	$ 101,682		$ 88,722	$ (12,960)	$ 386,667	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,039,988	$ 101,682		$ 88,722	$ (12,960)	$ 386,667	1
2	CARPETING	2000	5,270		20	264	264	594	2
3	TILING & DRYWALL	2000	5,900		20	295	295	615	3
4	COOLER REPAIR	2000	719		20	36	36	75	4
5	DOOR	2000	320		20	16	16	33	5
6	WALLPAPER	2000	3,919		20	196	196	441	6
7	WALLPAPER	2000	3,066		20	153	153	357	7
8	PARKING LOT PAVING	2000	8,775		20	439	439	878	8
9	REMODEL STAIRWELL	2001	1,080		20	54	54	72	9
10	DOORS & REFINISHING	2001	13,510		20	676	676	1,014	10
11	DOORS & REFINISHING	2001	1,725		20	86	86	122	11
12	DOORS & REFINISHING	2001	100		20	5	5	7	12
13	DOORS & REFINISHING	2001	1,925		20	96	96	136	13
14	DOORS & REFINISHING	2001	900		20	45	45	64	14
15	DOORS & REFINISHING	2001	300		20	15	15	20	15
16	DOORS & REFINISHING	2001	300		20	15	15	20	16
17	DOORS & REFINISHING	2001	1,300		20	65	65	87	17
18	DOORS & REFINISHING	2001	900		20	45	45	60	18
19	DOORS & REFINISHING	2001	600		20	30	30	40	19
20	BATHROOM IMPRVMNT	2001	641		20	32	32	45	20
21	DINING RM TILE	2001	720		20	36	36	51	21
22	BATHROOM FAUCET	2001	725		20	36	36	51	22
23	BATHROOM FIXTURES	2001	2,434		20	122	122	173	23
24	DRYWALL MAT'L FOR 2F	2001	375		20	19	19	27	24
25	DOOR FRAME	2001	315		20	16	16	23	25
26	TILE	2001	424		20	21	21	30	26
27	DOORS	2001	1,096		20	55	55	78	27
28	DOOR HINGES	2001	237		20	12	12	17	28
29	DOORS	2001	392		20	20	20	28	29
30	TILE	2001	198		20	10	10	14	30
31	BATHROOM FIXTURES	2001	228		20	11	11	16	31
32	BATHROOM FIXTURES	2001	821		20	41	41	58	32
33	BATHROOM FLOOR	2001	1,610		20	81	81	108	33
34	TOTAL (lines 1 thru 33)		$ 3,100,813	$ 101,682		$ 91,765	$ (9,917)	$ 392,021	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,100,813	$ 101,682		$ 91,765	$ (9,917)	$ 392,021	1
2	WALL GUARD	2001	715		20	36	36	48	2
3	WALL COVERING	2001	3,920		20	196	196	261	3
4	BATHROOM FLOOR	2001	3,283		20	164	164	219	4
5	LIGHT FIXTURES	2001	337		20	17	17	23	5
6	BATHROOM FIXTURES	2001	407		20	20	20	27	6
7	BATHROOM FIXTURES	2001	350		20	18	18	24	7
8	DOOR	2001	495		20	25	25	40	8
9	DOOR	2001	42		20	2	2	3	9
10	DOOR	2001	171		20	9	9	14	10
11	REPAIR CONCRETE IN R	2001	260		20	13	13	20	11
12	CARPET FOR REHAB RM	2001	493		20	25	25	38	12
13	REPAIR IFRE ALARM SY	2001	633		20	32	32	48	13
14	FIXTURES FOR REHAB R	2001	192		20	10	10	15	14
15	DOOR LOCKS	2001	367		20	18	18	27	15
16	FIXTURES FOR REHAB	2001	170		20	9	9	14	16
17	FIXTURES FOR REHAB R	2001	527		20	26	26	39	17
18	FIXTURES FOR REHAB R	2001	407		20	20	20	30	18
19	DOOR FRAMES	2001	315		20	16	16	24	19
20	CEILING TILE	2001	170		20	9	9	14	20
21	KICK PLATES FOR DRS	2001	1,591		20	80	80	120	21
22	NURSES STATION	2001	9,066		20	453	453	680	22
23	FIXTURES	2001	408		20	20	20	30	23
24	BATHROOM FLOOR	2001	1,375		20	69	69	98	24
25	WOOD STRIPS FOR THER	2001	3,929		20	196	196	278	25
26	CARPETING	2001	547		20	27	27	38	26
27	DECORATIVE MURAL	2001	1,286		20	64	64	91	27
28	REPAIR OF WATER SOFT	2001	2,418		20	121	121	242	28
29	DOOR	2001	1,295		20	65	65	125	29
30	REPAIR WATER HEATER	2001	1,956		20	98	98	188	30
31	FLOORING	2001	2,104		20	105	105	201	31
32	FLOORING	2001	2,517		20	126	126	242	32
33	INSTALL MAGNETICS LO	2001	589		20	29	29	51	33
34	TOTAL (lines 1 thru 33)		$ 3,143,148	$ 101,682		$ 93,883	$ (7,799)	$ 395,333	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,143,148	$ 101,682		$ 93,883	$ (7,799)	$ 395,333	1
2	DOORS	2001	328		20	16	16	28	2
3	STORE ROOM LOCK	2001	216		20	11	11	19	3
4	DOOR HANDLES	2001	309		20	15	15	26	4
5	DOOR HANDLES	2001	141		20	7	7	12	5
6	SHELVES	2001	717		20	36	36	63	6
7	NURSES STATION	2001	9,066		20	453	453	755	7
8	SHELVING	2001	480		20	24	24	40	8
9	DOOR KICK PLATES	2001	229		20	11	11	18	9
10	DOORS	2001	1,025		20	51	51	85	10
11	DRYWALL HALLS, NEW C	2001	2,650		20	133	133	222	11
12	STAIN FOR DOORS	2001	228		20	11	11	18	12
13	SIGNS	2001	744		20	37	37	59	13
14	CUSTOM WALL CABINETS	2001	9,266		20	463	463	733	14
15	DOORS	2001	429		20	21	21	33	15
16	WOODSTRIPS	2001	268		20	13	13	16	16
17	WALLPAPER	2001	1,980		20	99	99	124	17
18	FOOT RAILS	2001	1,962		20	98	98	123	18
19	WALLCOVERING	2001	2,793		20	140	140	175	19
20	WALLPAPER	2001	4,500		20	225	225	281	20
21	2ND FLOOR BULBS	2001	195		20	10	10	13	21
22	DOORS & REFINISHING	2001	1,500		20	75	75	94	22
23	SIGNS	2001	1,938		20	97	97	113	23
24	WALLPAPER & PLASTER	2001	3,400		20	170	170	198	24
25	ELEVATOR VOICE ACTIV	2001	1,500		20	75	75	88	25
26	DOOR LOCKS	2001	1,705		20	85	85	99	26
27	DOOR WIRING	2001	3,000		20	150	150	163	27
28	REMODELING - 2FL	2001	13,885		20	694	694	752	28
29	PLUMBING	2001	867		20	43	43	79	29
30	CARPETING	2002	15,541		20	2,035	2,035	2,035	30
31	TEMPERATURE CONTROL	2002	627		20	52	52	52	31
32	TEMPERATURE SWITCH	2002	560		20	47	47	47	32
33	MONITORING PANEL	2002	937		20	78	78	78	33
34	TOTAL (lines 1 thru 33)		$ 3,226,134	$ 101,682		$ 99,358	$ (2,324)	$ 401,974	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,226,134	$ 101,682		$ 99,358	$ (2,324)	$ 401,974	1
2	TILING	2002	963		20	36	36	36	2
3	WALLPAPER	2002	8,570		20	6,428	6,428	6,428	3
4	WALLCOVERING	2002	1,182		20	887	887	887	4
5	CEILING TILE	2002	919		20	34	34	34	5
6	STORAGE TANK	2002	2,199		20	165	165	165	6
7	KITCHEN LIGHTS	2002	1,124		20	75	75	75	7
8	COVE BASE	2002	728		20	49	49	49	8
9	WALL MOUNT COOLER	2002	530		20	31	31	31	9
10	SMOKE DETECTOR	2002	1,872		20	94	94	94	10
11	DOORS	2002	1,289		20	21	21	21	11
12	LIGHTING	2002	352		20	12	12	12	12
13	LIGHTING	2002	517		20	17	17	17	13
14	ROOFING	2002	4,265		20	178	178	178	14
15	WALL HEATERS & A/C	2002	5,259		20	175	175	175	15
16	LIGHT FIXTURES	2002	1,132		20	9	9	9	16
17	HEATING	2002	588		20	29	29	29	17
18	FIRE ALARM SYSTEM	2002	730		20	37	37	37	18
19	ALARM SYSTEM REPAIR	2002	563		20	28	28	28	19
20	ALARM SYSTEM REPAIR	2002	563		20	28	28	28	20
21	HEATING	2002	586		20	29	29	29	21
22	PHONE SYSTEM	2002	510		20	26	26	26	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,260,575	$ 101,682		$ 107,746	$ 6,064	$ 410,362	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,260,575	$ 101,682		$ 107,746	$ 6,064	$ 410,362	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,260,575	$ 101,682		$ 107,746	$ 6,064	$ 410,362	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,260,575	$ 101,682		$ 107,746	$ 6,064	$ 410,362	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,260,575	$ 101,682		$ 107,746	$ 6,064	$ 410,362	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,260,575	$ 101,682		$ 107,746	$ 6,064	$ 410,362	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,260,575	$ 101,682		$ 107,746	$ 6,064	$ 410,362	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1998		$ 2,544,733	$ 65,250	39	$ 65,250	$	$ 263,719	4
5	Dyn Alloc		1993		34,499	885		986	101	9,199	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,579,232	$ 66,135		$ 66,236	$ 101	$ 272,918	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 782,663	$ 118,647	$ 78,148	$ (40,499)	10	$ 463,483	71
72	Current Year Purchases	60,468		5,278	5,278	10	5,278	72
73	Fully Depreciated Assets	32,118				10	32,117	73
74								74
75	TOTALS	$ 875,249	$ 118,647	$ 83,426	$ (35,221)		$ 500,878	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		DODGE WAGON	1994	$ 27,533	$ 1,675	$ 2,753	$ 1,078	5	$ 23,171	76
77	Dynamic Allocation	Vehicle	2001	4,378	1,235	1,459	224	5	3,038	77
78										78
79										79
80	TOTALS			$ 31,911	$ 2,910	$ 4,212	$ 1,302		$ 26,209	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	4,495,594	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	223,239	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	195,384	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(27,855)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	937,449	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 4,964 Description: Oxygen/Compressors $1884; Oxygen Concentrators $500; Copier $2580
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation Dynamic		$	$ 6,398	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,398	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01	1265 hrs	$ 30,363		$ 17,377	$	1,265	$ 47,740	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			7,416			7,416	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			90,806			90,806	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				49,346		49,346	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						5,559		5,559	13
14	TOTAL			$ 30,363		$ 115,599	$ 54,905	1,265	$ 200,867	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 13,515	$ 48,423	1
2	Cash-Patient Deposits	25,601	25,601	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	419,204	419,204	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,318	30,318	6
7	Other Prepaid Expenses	460	460	7
8	Accounts Receivable (owners or related parties)	114,105	216,705	8
9	Other(specify): See Supplemental Schedule	14,087		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 617,290	$ 740,711	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,859	13
14	Buildings, at Historical Cost		2,544,733	14
15	Leasehold Improvements, at Historical Cost	640,969	640,969	15
16	Equipment, at Historical Cost	484,115	890,115	16
17	Accumulated Depreciation (book methods)	(450,803)	(1,018,611)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,000	6,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,000)	(6,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		19,960	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 674,281	$ 3,405,025	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,291,571	$ 4,145,736	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 197,049	$ 197,047	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,601	25,601	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,251	138,251	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,644	1,644	31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,000	54,000	32
33	Accrued Interest Payable	1,355	10,281	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,339	6,339	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 424,239	$ 433,163	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	366,000	366,000	39
40	Mortgage Payable		2,271,619	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 366,000	$ 2,637,619	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 790,239	$ 3,070,782	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 501,332	$ 1,074,954	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,291,571	$ 4,145,736	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 524,855	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 524,855	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	46,077	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(69,600)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (23,523)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 501,332	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,051,785	1
2	Discounts and Allowances for all Levels	(553,277)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,498,508	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	513,730	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 513,730	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	73,147	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,350	19
20	Radiology and X-Ray		20
21	Other Medical Services	3,268	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 88,765	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,263	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,263	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	540	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 540	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,113,806	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	749,380	31
32	Health Care	1,479,222	32
33	General Administration	882,110	33
	B. Capital Expense		
34	Ownership	676,603	34
	C. Ancillary Expense		
35	Special Cost Centers	216,904	35
36	Provider Participation Fee	63,510	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,067,729	40
41	**Income before Income Taxes (line 30 minus line 40)****	46,077	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 46,077	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,805	1,846	$ 46,126	$ 24.99	1
2	Assistant Director of Nursing	604	700	14,226	20.32	2
3	Registered Nurses	8,045	8,505	181,538	21.34	3
4	Licensed Practical Nurses	14,289	15,188	321,322	21.16	4
5	Nurse Aides & Orderlies	48,695	50,831	559,668	11.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,172	1,265	30,363	24.00	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,898	2,066	24,349	11.79	9
10	Activity Assistants	4,428	4,521	28,878	6.39	10
11	Social Service Workers	3,766	4,089	46,239	11.31	11
12	Dietician					12
13	Food Service Supervisor	1,606	1,774	25,130	14.17	13
14	Head Cook	4,860	5,243	56,165	10.71	14
15	Cook Helpers/Assistants	12,763	13,388	88,932	6.64	15
16	Dishwashers					16
17	Maintenance Workers	4,079	4,289	57,354	13.37	17
18	Housekeepers	10,904	11,404	77,155	6.77	18
19	Laundry	6,609	6,846	42,573	6.22	19
20	Administrator	1,882	2,286	58,339	25.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	928	1,096	12,632	11.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,817	2,906	31,758	10.93	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,035	1,162	16,037	13.80	33
34	TOTAL (lines 1 - 33)	132,185	139,405	$ 1,718,784 *	$ 12.33	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	186	$ 9,824	01-03	35
36	Medical Director	Monthly	1,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	64	2,048	10-03	38
39	Pharmacist Consultant	136	5,160	10-03	39
40	Physical Therapy Consultant	247	9,886	10a-03	40
41	Occupational Therapy Consultant	50	1,683	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	58	1,748	11-03	44
45	Social Service Consultant	25	1,500	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	766	$ 33,049		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,060	$ 42,404	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	8,993	103,424	10-03	52
53	TOTAL (lines 50 - 52)	10,053	$ 145,828		53

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pam Ingold	Administrator	0	$ 58,339
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 58,339

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 24,198
Health Data Systems	Data Processing	2,991
Dynamic Health Care	BookkeepingServices	255,400
Sachnoff & Weaver	Legal	6,801
Econocare	Purchasing Consultant	2,088
Personnel Planners	Unemployment Consultant	817
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 292,295

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,226
Unemployment Compensation Insurance	13,327
FICA Taxes	129,808
Employee Health Insurance	118,578
Employee Meals	15,713
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	5,109
TOTAL (agree to Schedule V, line 22, col.8)	$ 332,761

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	28,502
Health Care Worker Background Check	618
(Indicate # of checks performed 85)	
Dues & Subscriptions	4,105
Licenses & Permits	1,218
Dynamic Allocation	511
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,954

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,812
Dynamic Allocation	200
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,012

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Wallpaper	12/96	$ 4,919	3	$ 1,503	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,919		$ 1,503	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILLOW CREST NURSING PAVILION # 0036533 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $5918**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **713** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **63,510**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,713** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees